TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TX HEALTH DBA INJURY 1 OF DALLAS

Respondent Name
ACE AMERICAN INSURANCE CO

MFDR Tracking Number
M4-18-0053-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
SEPTEMBER 6, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPT codes 97545 WHCA & 97546 WHCA were preauthorized, #305041 therefore it is deemed medically necessary."

Amount in Dispute: $4,096.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon receipt of the MDR request, the bill was sent for additional review. An addendum response will be issued upon completion of that review."

Response Submitted By: ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Ordered
April 24, 2017 through May 4, 2017	CPT Codes 97545-WH-CA and 97546-WH-CA Work Hardening Program	$4,096.00	$4,096.00

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 denotes that the carrier is liability for preauthorized services.
3. 28 Texas Administrative Code §134.230 sets out the reimbursement guidelines for work hardening.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - TX06-Unnecessary treatment with peer review.
    - 18-Duplicate claim/service.
    - 148-This procedure on this date was previously reviewed.
    - 216-Based on the findings of a review organization.

Issues

1. Are the services in dispute eligible for payment?
2. What is the appropriate reimbursement for the services in dispute?

Findings

1. According to the submitted explanation of benefits, the disputed work hardening services were denied based upon reason code, **"**TX06-Unnecessary treatment with peer review." According to 28 Texas Administrative Code §133.307 (d)(2)(I), if the medical fee dispute involves medical necessity issues, the insurance carrier shall attach a copy of documentation that supports an adverse determination in accordance with §19.2005 of this title (relating to General Standards of Utilization Review). The carrier failed to provide documentation to support its medical necessity denial of the services in dispute.

   Additionally, 28 Texas Administrative Code §134.600 (c)(1)(B) states that a carrier is liable for the medical costs relate to health care that was preauthorized. Documentation provided by the requestor supports that preauthorization was obtained for the services in dispute. Specifically, the requestor provided a MediCall Review #302041, dated April 21, 2017, addressed to Alfred McElroy, D.C. certifying that 80 hours of work hardening between April 18, 2017 and June 17, 2017 was medically necessary.

   The Division finds that the carrier failed to support its reason for denial, and that the carrier is liable for the costs of the work hardening program because the services were preauthorized. The services in dispute are therefore eligible for payment under the applicable Division fee guideline.

2. The requestor is seeking additional reimbursement for a work hardening program rendered to the injured worker from April 24, 2017 through May 4, 2017.

   The fee guidelines for work hardening services is found in 28 Texas Administrative Code §134.230.

   28 Texas Administrative Code §134.230(1) states "Accreditation by the CARF is recommended, but not required.
   (A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the maximum allowable reimbursement (MAR).
   (B) If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR."

   The requestor billed 97545-WH-CA and 97546-WH-CA with the CA modifier; therefore, the disputed program is CARF accredited and reimbursement shall be 100% of the MAR.

   28 Texas Administrative Code §134.230 (3) states "For division purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening.
   (A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT code 97545 with modifier "WH." Each additional hour shall be billed using CPT code 97546 with modifier "WH." CARF accredited programs shall add "CA" as a second modifier.

   (B) Reimbursement shall be $64 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

   The appropriate reimbursement is 64 hours X $64.00 = $4,096.00. The respondent paid $0.00. The difference between the amount due and paid is $4,096.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $4,096.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $4,096.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		12/01/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.